EXHIBIT 1

For Federal civil complaint
Brian David Hill v. Executive Office for United States Attorneys (EOUSA), United States Department of Justice (U.S. DOJ)

www.dmvNow.com
Virginia Department of Motor Vehicles
Post Office Box 27412
Richmond, Virginia 23269-0001

MED 10 (02/17/2011)

DISABLED PARKING PLACARDS OR LICENSE PLATES APPLICATION

Purpose: Use this form to apply for a disabled parking placard or disabled parking license plates.

Instructions: Submit to any Customer Service Center, DMV Select or mail to DMV, Data Integrity, P.O. Box 85815, Richmond, VA 23285-5815.

- For a parking placard, submit this form with a $5.00 check or money order payable to DMV. Placard will be mailed to you in approximately 15 days. Only one placard may be issued to a customer.
- For disabled parking license plates, submit this form, a License Plate Application (VSA 10) and applicable fees.

DISABLED PARKING PLACARD ONLY
(Disabled parking placard hangs from the rearview mirror.)

CHECK ONE

PERMANENT (5 years)	PERMANENT REPLACEMENT (5 years)	TEMPORARY (up to 6 months)	TEMPORARY REPLACEMENT
☑ Original (medical professional certification required)	☐ Lost ☐ Stolen	☐ Original	☐ Lost ☐ Stolen
☐ Renewal (No medical professional certification required.)	☐ Destroyed ☐ Mutilated		☐ Destroyed ☐ Mutilated
	☐ Reissue		☐ Reissue

DISABLED PARKING (HP) LICENSE PLATES ONLY

ORIGINAL PLATES	DUPLICATE	REISSUE	
☐ Complete and submit form VSA 10	☐ Lost ☐ Destroyed	☐ Unreadable (License plate letters or numbers unclear) ☐ Never received license plates	☐ Check this box if this vehicle is specifically equipped and used for transporting groups of physically disabled persons.

VEHICLE IDENTIFICATION NUMBER (VIN) | TITLE NUMBER

☐ I am the vehicle owner and the parent/legal guardian of a disabled dependent(s). List the name of each disabled person below.

APPLICANT INFORMATION

FULL LEGAL NAME (last)	(first)	(middle)	(suffix)	DMV ASSIGNED NUMBER OR SOCIAL SECURITY NUMBER
HILL	BRIAN	David		[redacted]

CURRENT RESIDENCE ADDRESS	CITY	STATE	ZIP CODE
310 Forest St., Apt. 2 ☑ Check here if this is a new address.	Martinsville	VA	24112

CITY OR COUNTY OF RESIDENCE	DAYTIME TELEPHONE NUMBER OR CELL PHONE NUMBER
Martinsville	(276) 790-3505

MAILING ADDRESS (if different from above)	CITY	STATE	ZIP CODE

BIRTH DATE (mm/dd/yyyy)	GENDER	HAIR COLOR	EYE COLOR	HEIGHT	WEIGHT
	☐ MALE ☐ FEMALE			FT IN	LBS

APPLICANT CERTIFICATION

I understand that misuse, counterfeiting, or alteration of disabled placards may result in fines up to $1000. and up to 6 months in jail and/or revocation of disabled parking privileges. I certify that I have a (check one): ☐ Temporary ☑ Permanent disability that limits or impairs my ability to walk or creates a safety concern while walking.

I also understand that the disabled parking placard or plates issued to me cannot be loaned to anyone, including family members or friends, to benefit a person other than myself.

I further certify and affirm that all information presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

APPLICANT SIGNATURE	DATE (mm/dd/yyyy)
Brian D. Hill Signed	08/18/2016

LICENSED PHYSICIAN/PHYSICIAN ASSISTANT/NURSE PRACTITIONER MEDICAL CERTIFICATION

(This section does not have to be completed to renew permanent placards.)

☒ Permanently limited or impaired. A permanent disability as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in Virginia Code §46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.

☐ Temporarily limited or impaired beginning in the month of _____ and ending in the month of _____ (not to exceed 6 months).

Reason this patient's ability to walk is limited or impaired or creates a safety condition while walking. (check below)

☐ Cannot walk 200 feet without stopping to rest.

☐ Uses portable oxygen.

☐ Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.

☐ Has a cardiac condition to the extent that functional limitations are classified in severity as Class III or Class IV according to standards set by the American Heart Association.

☐ Is restricted by lung disease to such an extent that forced (respiratory) expiratory volume for one second, when measured by spirometry, is less than one liter, or the arterial oxygen tension is less than 60 millimeters of mercury on room air at rest.

☐ Is severely limited in ability to walk due to an arthritic, neurological, or orthopedic condition.

☒ Has been diagnosed with a mental or developmental amentia or delay that impairs judgment including, but not limited to, an autism spectrum disorder.

☐ Has been diagnosed with Alzheimer's disease or another form of dementia.

☐ Is legally blind or deaf.

☐ Other condition that limits or impairs the ability to walk. Specific condition description must be specified below.

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking as described above.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

MEDICAL PROFESSIONAL NAME	OFFICE TELEPHONE NUMBER	OFFICE FAX NUMBER
SHYAM BALAKRISHNAN	(276) 670 3300	(276) 634-0362

LICENSE TYPE	LICENSE NUMBER (required)	STATE ISSUING LICENSE (required)	LICENSE EXPIRATION DATE (mm/dd/yyyy) (required)
MD	[redacted]	VA	[redacted]

MEDICAL PROFESSIONAL SIGNATURE	DATE (mm/dd/yyyy)
[redacted]	8/3/16

LICENSED CHIROPRACTOR OR PODIATRIST MEDICAL CERTIFICATION

(This section does not have to be completed to renew permanent placards.)

☐ Permanently limited or impaired. A permanent disability as it relates to disabled parking privileges shall mean: a condition that limits or impairs movement from one place to another or the ability to walk as defined in Virginia Code §46.2-1240, and that has reached the maximum level of improvement and is not expected to change even with additional treatment.

☐ Temporarily limited or impaired beginning in the month of _____ and ending in the month of _____ (not to exceed 6 months).

Reason this patient's ability to walk is limited or impaired or creates a safety condition while walking. (Checked below)

☐ Cannot walk 200 feet without stopping to rest.

☐ Cannot walk without the use of or assistance from any of the following: another person, brace, cane, crutch, prosthetic device, wheelchair, or other assistive device.

☐ Is severely limited in ability to walk due to an arthritic, neurological or orthopedic condition.

☐ Other condition that limits or impairs the ability to walk. Specific condition description must be specified below.

I certify and affirm that the described applicant is my patient, whose ability to walk, based on my examination, is limited or impaired or creates a safety concern while walking as described above.

I further certify and affirm that to the best of my knowledge and belief, all information I have presented in this form is true and correct, that any documents I have presented to DMV are genuine, and that the information included in all supporting documentation is true and accurate. I make this certification and affirmation under penalty of perjury and I understand that knowingly making a false statement or representation on this form is a criminal violation.

MEDICAL PROFESSIONAL NAME	OFFICE TELEPHONE NUMBER	OFFICE FAX NUMBER
	( )	( )

LICENSE TYPE	LICENSE NUMBER (required)	STATE ISSUING LICENSE (required)	LICENSE EXPIRATION DATE (mm/dd/yyyy) (required)

MEDICAL PROFESSIONAL SIGNATURE	DATE (mm/dd/yyyy)

DMV USE ONLY

PLATE/PLACARD NUMBER	PLACARD EXPIRATION DATE (mm/dd/yyyy)	EMPLOYEE STAMP

CUSTOMER CREDIT CARD NUMBER	CREDIT CARD EXPIRATION DATE (mm/yy)	FEE COLLECTED

Brian Hill
7/18/2016 3:30 PM Office Visit

Provider: **Demetrios Herodotou, MD**
Department: **Carilion Clinic, Endocrinology**
Dept Phone: **540-224-5170**

Patient Preferred Name

No data filed

Basic Information

Date Of Birth	Sex	Race	Ethnicity	Preferred Language
5/26/1990	Male	White or Caucasian	Non-Hispanic	English

Department

Name	Address	Phone	Fax
Carilion Clinic, Endocrinology	3 Riverside Circle Roanoke VA 24016	540-224-5170	540-983-8229

Reason for Visit

Follow-up

Diabetes type 1

Reason for Visit History

Your Vitals Were

BP	Pulse	Ht	Wt	BMI	Smoking Status
132/78 mmHg	89	1.753 m (5' 9")	92.126 kg (203 lb 1.6 oz)	29.98 kg/m2	Never Smoker

To Do List

Friday September 02, 2016 10:45 AM Appointment with Herodotou, Demetrios at Carilion Clinic, Endocrinology (540-224-5170)
3 Riverside Circle
Roanoke VA 24016

Pending Health Maintenance

	Date Due	Completion Dates
TDAP IMMUNIZATION	**5/26/2001**	—
DIABETIC FOOT EXAM	**5/26/2008**	—
DIABETIC EYE EXAM	**5/26/2008**	—
DIABETIC 6 MONTH HGA1C	11/6/2016	5/6/2016, 2/1/2016, 10/22/2015, 7/2/2015, 5/4/2015, 1/19/2015, 3/22/2013

Allergies

Anesthetic [Benzocaine-Aloe Vera] Resident gets out of control	Other - See Comments
Vaccine Adjuvant Emulsion Combination No. 1 Resident stated he gets out of control	
Zantac [Ranitidine Hcl]	Diarrhea

Your Current Medications Are

insulin aspart (NOVOLOG FLEXPEN) 100 unit/mL Insulin Pen (Taking)	10 Units by Subcutaneous route as directed for Other (follow the sliding scale.)
insulin glargine (LANTUS) 100 unit/mL Solution (Taking)	36 Units by Subcutaneous route every night
omeprazole (PRILOSEC OTC) 20 mg Tablet, Delayed Release (E.C.) (Taking)	take 1 Tab by mouth every day
BD INSULIN SYRINGE ULTRA-FINE 0.5 mL 31 gauge x 5/16 Syringe	1 Each by Subcutaneous route four times daily
BD INSULIN PEN NEEDLE UF MINI 31 X 3/16" (BD INSULIN PEN NEEDLE UF MINI)	1 Each by Subcutaneous route four times daily

Your Current Medications Are (continued)

31 gauge x 3/16" Needle	
Insulin Needles, Disposable, (BD INSULIN PEN NEEDLE UF SHORT) 31 gauge x 5/16" Needle	1 Units by Does not apply route four times daily
glucose blood VI test strips (FREESTYLE INSULINX TEST STRIPS) Strip	1 Strip by external route three times daily
Blood-Glucose Meter (ACCU-CHEK AVIVA PLUS METER) Misc	1 Device by Does not apply route three times daily
Insulin Syringe-Needle U-100 (BD INSULIN SYRINGE ULTRA-FINE) 1 mL 30 x 1/2" Syringe	1 Each by Does not apply route four times daily

Pharmacy

WALGREENS DRUG STORE 12495 - MARTINSVILLE, VA - 2707 GREENSBORO RD AT NWC OF RIVES & US 220

2707 GREENSBORO RD MARTINSVILLE VA 24112-9104
Phone: 276-632-0180 Fax: 276-632-6759
Open 24 Hours?: No